ADVANCED ENDODONTIC GROUP

Informed Consent

I _____ have been advised by Epelman that I require endodontic/root canal treatment on tooth# _____

I understand that root canal treatment is an attempt to save my tooth due to loss of vitality from infections, decay, trauma, crack or to obtain sufficient retention for restoration. The alternative to root canal treatment is extraction.
I understand that following my root canal treatment I should continue my dental treatment by placing a crown or other proper restoration on the tooth. **I understand that failure to continue with initiated treatment and a final restoration may result in the eventual loss of the tooth through decay, fracture, or extraction,** if this occurs, I cannot hold the dentist who initiated the treatment responsible.
I understand that I am responsible for obtaining recommended follow.
up care and treatment and understand the consequences of failing to continue with treatment or failing to get a final restoration.
I understand that at any time during treatment, common medications may be prescribed that may have side effects such as nausea and diarrhea. If any adverse side effects such as itching, rash or hives occur, I am to stop the medication and call the dentist who prescribed them.
I have discussed the root canal procedure with my endodontist and I understand that the following risks and complications may arise:

1. Root canal treatment requires anesthesia and multiple radiographs (xrays).
2. Local anesthesia injection sometimes causes trismus (difficulty in jaw opening) or paresthesia (temporary or permanent loss of sensation) or bruising.
3. Postoperative discomfort or swelling, lasting a few hours to several days, for which medication will be prescribed if deemed necessary by the dentist.
4. Allergic or unanticipated reactions to medication or anesthetics may occur.
5. Separation of root canal instruments during treatment which may, in judgment of the dentist, be left in the treated root canal or require surgical procedure for removal or retreatment of the root canal to retrieve the separated instrument.
6. Perforation of the tooth or the root canal due to curved roots or preexisting extensive decay or restorations. This may require additional nonsurgical treatment, surgical treatment or extraction.
7. Premature tooth loss may result from cracks or fractures that are preexisting or that can occur during the root canal treatment or post root canal treatment.
8. Access through a crown or bridge or any other existing restoration may result in damage to the tooth and / or restoration. This may require additional nonsurgical treatment, surgical treatment or extraction.
9. Complications during and after the procedure may include but are not limited to porcelain fracture or dislodgement of the crown or existing restoration.
10. The tooth may be deemed non restorable after the root canal treatment is completed due to fracture or examination of further decay under existing crown or restoration.
11. Treatment may be discontinued due to calcified canals, separation of root canal instruments or reamers, or fractures of root or crown.
12. Success rate of root canal treatment is approximately 93% (If failure occurs, the treatment may have to be redone, surgerized, or the tooth extracted). The success rate of surgical root canal treatment is approximately 70%.
13. Postsurgical complications include: discomfort and pain, swelling, bruises, excessive bleeding, trismus, and injury to the nerve underlying the teeth which may result in numbness or tingling of the lip, chin, gums or tongue. This may persist for several weeks, months, or in remote instances permanently. Also, there may be exposure to the sinus in the upper teeth.
14. The crown of the tooth may darken eventually and /or become brittle due to loss of vitality.
15. Failure to seek treatment and proper restoration on the endodontically treated tooth within 34 weeks can lead to tooth loss or further fracture.
16. Root canal therapy performed through crowns may hide existing decay or cracks, which are not visible during treatment, and therefore I cannot hold the dentist responsible for missing them.

By signing below, I (as the patient, the parent/guardian with authority to give consent for a patient or other legally authorized representative of a patient), certify that:

1. I have read and understand the terms of this document and the explanations I have received; and
2. that after careful consideration, I consent to dental treatment provided by Advanced Endodontic Group.

Patient/Parent/Guardian _____ Date _____ DOB _____